Clark County
Regional Support Network
Policy Statement

Policy No.:	**CM04**	**MIS Data Dictionary 2.03.01, 2.07.04,**
Policy Title:	**Authorization For Outpatient Services**	**2.07.05 & 5.05**
Effective Date:	**September 1, 2001**	

Policy: Out-patient mental health services provided to Medicaid beneficiaries shall be authorized for payment by Clark County Regional Support Network based on CCRSN established eligibility criteria and currency of Medicaid eligibility. CCRSN contracted providers shall provide the clinical and financial information required to submit a request for authorization for services. CCRSN authorization decisions shall be made by Care Managers with appropriate clinical experience and in a timely manner. Authorizations shall designate the level of care as well as the element of care to be provided to the Medicaid enrollee.

Reference: WAC 388-865, Washington State Mental Health Division CCRSN Interlocal Agreement, 42 CFR 400, CCRSN Policy and Procedure: CM07 Eligibility Criteria & Access to Care Standards, CM07-A Access to Care Standards-Adult, CM13 Assessment and Intake- Adult, CM36 Notice of Action, QM05 Element of Care Clinical Guidelines.

Procedure:

Providers

1. CCRSN contracted providers shall submit requests for authorization of mental health services through the CCRSN Management Information System. Authorization requests must include all required demographic, financial, and clinical information as described in the MIS and CCRSN policies and procedures referenced in this policy.

2. Required clinical information shall be based on a mental health assessment conducted by a credentialed Mental Health Professional that includes a five axis DSM diagnosis and a clinical formulation with an initial determination of medical necessity. For consumers with a Diagnosis on the "B" list in the Access to Care Standards (CM 07-A) who are initially determined by the Mental Health Professional to meet one of the four exception criteria, providers shall list the exception by number, with substantiating clinical narrative, on the Diagnosis Screen in the MIS.

    a. Providers shall specify the element of care the Mental Health Professional initially determines is medically necessary to meet the needs of the Medicaid enrollee.

    b. Service requests for *Intensive and Crisis Stabilization Elements of Care* require a face-to face evaluation by the Children's Mobile Outreach Team or SW Washington Medical Center Crisis Team staff (Crisis Stabilization only) for children and adolescents.

3. Providers shall verify Medicaid eligibility before including financial information in an authorization request.

CCRSN Care Management

1. CCRSN Care managers shall be determined by CCRSN to have the clinical experience necessary to make authorization decisions, including verified credentials of a Mental Health Professional.

2. CCRSN Care managers shall make the final determination of medical necessity and element of care based on the clinical and financial information submitted in the authorization request through the MIS. CCRSN Care Managers may review the following information in the MIS in making an authorization decision:
   a. DSM diagnosis, including the Global Assessment of Functioning score
   b. Past treatment and service utilization history
   c. Clinical narratives
   d. High Risk and Crisis Plan screens
   e. In-patient psychiatric hospitalization history
   f. Financial eligibility data

3. The Care Manager shall re-verify Medicaid eligibility, using CCRSN-approved technology.

4. After reviewing the required clinical and financial information in the authorization for services request, the Care Manager shall:
   a. *Approve* the authorization as requested, or
   b. *Pend* an authorization if the authorization request is incomplete or more clinical information is needed.
      1. Providers will be asked to provide additional clinical or financial information for a pended authorization. If additional information is not provided within fourteen (14) days of the pend date, and if the enrollee or requesting provider do not request an extension (see 8a below) the CCRSN Care Manager will make the authorization decision based on the information available.
   c. *Deny* an authorization if the person requesting services does not have Medicaid coverage, does not meet the Access to Care Standards, if the Care Manager plans to authorize a different element of care than the one requested.
      1. The Care Manager shall request the provider submit a new authorization request for the element of care the Care Manager plans to authorize, through the MIS.
         a. If the authorized element of care limits the type, frequency, duration, or scope of covered Medicaid mental health services, CCRSN shall provide notice of action to the requesting provider and to the Medicaid enrollee, as specified in CM 36 Notice of Action.

5. CCRSN Care Managers shall make an authorization decision within twenty-four (24) hours of receipt of an authorization request. For pended authorizations, CCRSN shall adhere to the following timeframes for authorization decisions:

   a. *Standard authorization decisions:* CCRSN shall provide notice of the authorization decision as expeditiously as the enrollee's health condition requires, not to exceed 14 calendar days

following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee or the provider requests an extension. A request for extension may be filed verbally or in writing with a CCRSN Care Manager.

1. CCRSN shall monitor the use and pattern of extensions and apply corrective action or initiate quality improvement activities where necessary.

b. *Expedited authorization decisions*: for cases in which a provider indicates, and the CCRSN Care Manager determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the CCRSN shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

1. CCRSN may extend the 3 working days time period by up to 14 calendar days if the enrollee or the provider requests an extension or if CCRSN justifies to the Washington Mental Health Division upon request, a need for additional information and how the extension is in the enrollee's interest. A request for extension may be filed verbally or in writing with a CCRSN Care Manager.
2. CCRSN shall monitor the use and pattern of expedited authorization requests and apply corrective action or initiate quality improvement activities when necessary.

6. Mental health treatment may only begin when the CCRSN contracted-provider receives an authorization for services from CCRSN.

Enrollee Notification of Authorized Services

1. CCRSN providers shall verbally notify consumers of approved authorizations upon receipt of electronic notification from CCRSN.
2. Authorization information to the consumer shall include level/element of approved care, included service modalities, and time frame of services.
3. Compliance with this requirement is ensured through review of medical records twice annually.

Approved By: Michael Piper Date: 11-23-05

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